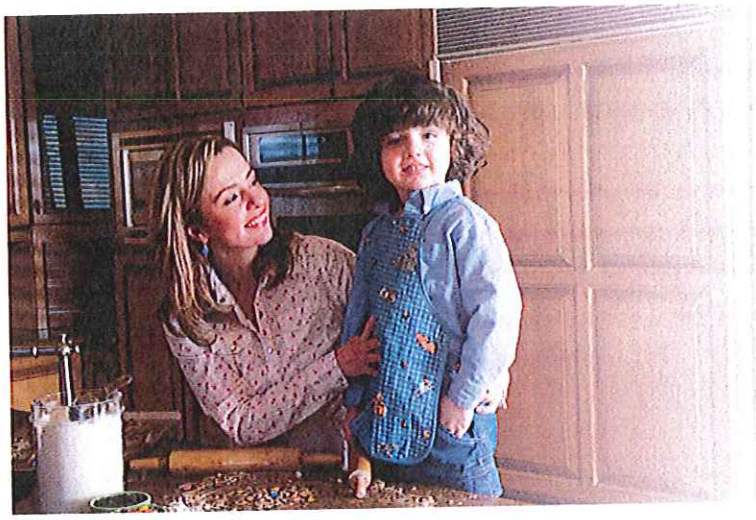

WHAT HAPPENS IF YOU GET HURT?

AccidentAdvance℠
24-hour accident insurance

*Underwritten by **Transamerica Life Insurance Company**, Cedar Rapids, Iowa..*

Are we covered for that?

Accidents and injuries can happen at any place at any time. As one of your employer's most important assets, it is important to protect yourself and make sure you can bounce back from whatever life may throw at you. Transamerica Life Insurance Company's AccidentAdvance offers benefits for accidents. It also offers features to promote healthier behavior in general. It is an advancement in accident coverage. It is AccidentAdvance.

Pays in addition to any other coverage and is Guaranteed Issue.

Help offset your major medical deductible

Dependent coverage available

Auto accident benefit

Convenient Payroll Deduction

Guarantee issue Coverage

Understanding AccidentAdvance℠

AccidentAdvance is an accident only insurance policy. Individual and family coverage is available. Issue ages for employees and spouses are 18 through 64. Eligible children can have coverage through age 25. Base coverage includes Accident Emergency Treatment, Follow-Up Visit and Physical Therapy, Initial Accident Hospitalization.

Riders Included in Coverage

- Accidental Death and Dismemberment Rider
- Accident Hospital and ICU Indemnity Income Rider
- Accident-Only Expanded Benefits Rider
- Wellness Benefit Rider

Coverage	Weekly Premium
Employee	$ 5.61
Employee and Child(ren)	$ 7.02
Employee and Spouse	$ 8.64
Employee, Spouse and Child(ren)	$ 10.39

TRANSAMERICA®
Employee Benefits

This is a brief summary of AccidentAdvance, 24-hour Accident Insurance.
Policy form series CPACC100 and CCACC100.

Forms and form numbers may vary, coverage available where approved.
Limitations and Exclusions apply. Refer to the policy, certificate and riders for complete details.

CAV01C(Pape)-0912

CUSTOM PLAN DESIGN

24-hour Accident Insurance

Accident Emergency Treatment (Module One)

Accident Emergency Treatment Benefit
For physician treatment and X-rays in a hospital or doctor's office within 96 hours of the accident. — $ 300

Major Diagnostic Examination Benefit
For one CT Scan, MRI, or EEG completed within 90 days of the accident. — $ 480

Dislocation Benefit
For dislocations reduced under general anesthesia. A dislocation reduced without general anesthesia is limited to 25% of the benefit amount for the dislocation involved. Benefits are payable only for the first dislocation of a joint. If multiple dislocations are reduced, we will pay 1½ times the highest benefit amount and no other amount will be paid under this benefit.

Reduction	Open	Closed
Hip	$ 9,600	$ 3,240
Knee or Shoulder	$ 3,240	$ 1,320
Collar Bone	$ 5,160	$ 960
Ankle or Foot (except toes)	$ 3,240	$ 960
Lower Jaw	$ 3,240	$ 1,680
Wrist or Elbow	$ 2,640	$ 1,320
Toe or Finger	$ 720	$ 360

Fractures Benefit
For repair of a fracture sustained in an accident. A chip fracture is paid 10% of the fracture's benefit amount. Multiple repaired fractures are paid 1½ times the highest benefit amount. No other amount will be paid under this benefit.

Reduction	Open	Closed
Coccyx	$ 1,680	$ 840
Hand (except fingers), Foot (except toes/heel), Wrist, Shoulder Blade, Forearm, Ankle, Elbow, Kneecap, Sternum or Lower Jaw	$ 4,080	$ 2,040
Hip	$ 12,000	$ 4,080
Leg	$ 5,040	$ 4,080
Nose, Heel or Fingers	$ 4,080	$ 840
Ribs	$ 8,040	$ 840
Skull	$ 6,480	$ 2,400
Toes	$ 1,680	$ 840
Upper Jaw, Upper Arm or Face (except Nose), Collar Bone	$ 4,800	$ 2,040
Vertebrae, Pelvis	$ 2,040	$ 2,040
Vertebral Process	$ 8,040	$ 1,200

For both dislocations and fractures, 1½ times the highest dislocation or fracture benefit amount is paid. No other dislocation or fracture benefit is paid.

Follow-Up Visits and Physical Therapy (Module Two)

Accident Follow-Up Treatment Benefit
Maximum of three (3) follow-up visits per accident. Original treatment must have been within 96 hours of the accident. Treatment must be provided by a physician in their office or in a hospital on outpatient basis; begin within 30 days of, and be completed within the 6 month following the later of: the accident; discharge from the hospital from a covered confinement; or discharge from an extended care facility. — $ 50

Physical Therapy Benefit - Maximum of 10 treatments per accident
For physical therapy treatments performed by a licensed Physical Therapist under the advice of a physician. Treatment must begin within 120 days of the accident and be completed within 1 year of the accident. — $ 50

Initial Accident Hospitalization (Module Three)

Initial Accident Hospitalization Benefit
Payable once for the first hospital admission due to an accident. Benefit is payable once for the first Intensive Care Unit admission due to an accident. The ICU benefit is paid even if admitted to the hospital initially and then transferred to ICU later during the same hospitalization. — $ 1,050

Ambulance Benefit
For transportation to the nearest hospital for treatment with 96 hours of the accident by a licensed ambulance service.

Ground Ambulance	$ 210
Air Ambulance	$ 1,050

Additional Riders

The following riders are optional. The policyholder selects which riders to include as well as the benefit level for each rider. The selected riders will be included for all applicants.

Accidental Death and Dismemberment Rider (Form No. CRADD300)

Accidental Death Benefit

Death must result from and occur within 90 days of the accident. Only 1 of the following benefits will be paid per covered person per accident. This benefit will be reduced by any dismemberment benefits previously paid for the same accident. Child benefit is 50% of the benefit amount.

Common Carrier Accidental Death For death resulting from a covered accident that occurs while riding as a fare-paying passenger on a mode of public transportation.	$ 90,000
Automobile Accidental Death If the covered person was:	
wearing and properly utilizing a seat belt and was seated in a position protected by an air bag system that deployed during the accident, as evidenced by police report.	$ 66,000
wearing and properly utilizing a seat belt, as evidenced by police report, but an air bag was not present or was not deployed.	$ 60,000
not wearing a seat belt.	$ 45,000
Benefits are not payable if a covered person was driving without a valid drivers' license.	
Other Accidental Death Other than those described above.	$ 30,000
Transportation of Remains Benefits For transporting remains to a mortuary near the covered person's primary residence if death occurs more than 200 miles from primary residence. Child benefit is 50% of the benefit amount.	$ 1,200

Additional Benefits for Accidental Death

If an accidental death benefit is payable, the following benefits will be paid to the survivor. A reduced benefit will be paid to the beneficiary if no eligible survivor. Benefits do not require a spouse or child to be covered under this rider.

Surviving Child Educational Benefit Payable for each eligible child ages 17 though 21, who is a full-time student at an accredited college, university, 2-year college, vocational or trade school within 365 days of the accidental death. Payable each year for up to 4 years while the child remains a full-time student.	$ 2,400
Licensed Day Care Center Benefit child must be between newborn and 12 and attending a licensed day care, who is not an immediate family member, within 90 days from the date of the accidental death. The day care must be necessary for the survivor to work or obtain training for work.	$ 900
Career Enrichment Benefit Survivor must be a full-time student at a professional or trade training program from an accredited college, university, two-year college, vocational, or trade school within 24 months of the accidental death. Training must be for the purpose of obtaining an independent source of income or enriching the survivor's ability to earn a living. This benefit will be paid for up to 4 years while the survivor remains a full-time student. Benefit not available for children.	$ 2,400

Accidental Dismemberment Benefits

Dismemberment must occur within 90 days of the accident. If accidental death benefit is payable after dismemberment benefits have been paid for the same accident, we will deduct the dismemberment benefits paid from the accidental death benefit due. Child benefit is 50% of the benefit amount.

One or more fingers or toes	$ 1,500
One eye, hand, foot, arm or leg	$ 6,000
Two eyes, hands or feet	$ 15,000
Speech or hearing in both ears	$ 15,000
Two arms or two legs	$ 15,000
Speech and hearing in both ears	$ 30,000
Both arms and both legs	$ 30,000
Total dismemberment benefits per covered person per accident will not exceed:	$ 30,000

Accident Hospital and ICU Income Rider (Form No. CRHICU00)

Accident Hospital Income Benefit For hospital confinement for treatment of injuries beginning within 30 days of the accident. Benefit is payable for up to 365 days per accident.	$ 100
Accident ICU Benefit For ICU confinement while the person is receiving the hospital income benefit. Benefit is payable for up to 15 days per accident.	$ 300

Expanded Benefits Rider (Form No. CREXPB00)

The following benefits are payable once, per person, per accident for injuries sustained in a covered accident.

Burns Must be treated by a physician within 96 hours of the accident. One or more skin grafts for a covered burn will be paid at 50% of the burn benefit amount paid for the burn involved.	Second-degree burns of body surface:	At least 25%, but not more than 35%	$ 300
		More than 35%	$ 750
	Third-degree burns of body surface:	6 through 10 square centimeters	$ 750
		10 through 25 square centimeters	$ 2,000
		25 through 35 square centimeters	$ 4,500
		more than 35 square centimeters	$ 6,000
Lacerations Must be treated or repaired within 96 hours of the accident.	Lacerations not requiring sutures		$ 20
	Single laceration less than 7.5 centimeters		$ 40
	Lacerations 7.6 to 20 centimeters		$ 150
	Lacerations over 20 centimeters		$ 300
Eye Injury	With surgical repair		$ 200
	Non-surgical removal of foreign body by physician		$ 35
Emergency Dental Work	One or more broken teeth repaired with crowns		$ 150
	One or more broken teeth resulting in extractions		$ 40
Brain Concussion Must be diagnosed by a physician within 96 hours of the accident.			$ 100
Coma Unconsciousness for 14 consecutive days with no reaction to external stimuli, no reaction to internal needs and require the use of life support systems.			$ 7,500
Paralysis Lasting a minimum of 30 days.	Quadriplegia (paralysis of four limbs)		$ 7,500
	Paraplegia (paralysis of lower limbs)		$ 3,750
Tendons, Ligaments and/or Rotator Cuffs Must be detached, torn, ruptured or severed and surgically repaired by a physician within one year of the accident. Only one benefits is payable.	Arthroscopic surgery	without repair	$ 100
		with one repair	$ 250
		with two or more repairs	$ 500
Ruptured Discs and/or Torn Knee Cartilage Must be surgically repaired by a physician within one year of the accident. Only one of these benefits is payable.	Shaved cartilage or arthroscopic surgery	without repair	$ 100
		with one repair	$ 250
		with two or more repairs	$ 500
Major Surgery For an open abdominal, cranial or thoracic surgery performed by a physician within one year of the accident. Laparoscopic procedures are excluded.			$ 750
Appliance For a physician-recommended medical appliance to aid personal locomotion, such as crutches, leg braces, wheelchairs and walkers. This benefit is not payable for prosthetic devices.			$ 100
Prosthetic Devices For one or more prosthetic devices received within one year of the accident. This benefit is not payable for hearing aids, dental aids (including false teeth), glasses, cosmetic prosthetic devices, such as wigs, or joint replacement, such as an artificial hip or knee.	One prosthetic device		$ 375
	Two or more prosthetic devices		$ 750
Blood, Plasma and Platelets Required for the treatment of injuries due to a covered accident. Immunoglobulins are not covered.			$ 200
Transportation Benefit is payable for up to two round trips to the hospital per accident per covered person if special treatment and hospital confinement occurs within 30 days of the accident. The local attending physician must prescribe treatment that is not available locally. Benefit is not payable for transportation to any hospital within a 100-mile radius of the accident site or covered person's residence.			$ 300

Family Lodging

Benefits are payable per day, maximum of 30 days, for one motel/hotel room for a member of the immediate family to accompany the covered person for treatment of injuries prescribed by a physician. Hospital confinement must be in a facility at least 100 miles from the covered personís residence and confinement must begin within 30 days of the accident. Benefits are not payable for services rendered by an immediate family member. **$ 75**

Wellness Benefit (Form No. CRWELB00) **Not available in Connecticut, DC, Kansas, or Massachusetts**

After a 30-day waiting period, benefit is payable per calendar year for one annual health screening test for the covered employee/member and one test for a covered spouse. **$ 50**

Blood test for triglycerides	CA 15-3 (breast cancer blood test)	Flexible sigmoidoscopy	Serum cholesterol test to determine HDL/LDL level
Bone marrow testing	CEA (colon cancer blood test)	Hemocult stool analysis	Serum Protein Electrophoresis (myeloma blood test)
Breast ultrasound	Chest X-ray	Mammography	Stress test on a bicycle or treadmill
CA 125 (ovarian cancer blood test)	Colonoscopy	Pap test	Thermography
	Fasting blood glucose test	PSA (prostate cancer blood test)	

Exclusions and Limitations

We will not pay benefits for losses caused by or as a result of a covered person:

- Driving any taxi for wage, compensation or profit; (In Idaho and Oregon, this exclusion does not apply)
- Mountaineering, parachuting or hang gliding; (In Idaho and Oregon, this exclusion does not apply)
- Voluntarily taking, administering, absorbing or inhaling poison, gas or fumes; (In Connecticut, voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by the covered person's physician), (In Idaho, this exclusion does not apply), (In Oregon, unless the exposure occurs in the course of employment), (In Tennessee, must be done intentionally);
- Alcoholism or drug addiction; (In California, this exclusion does not apply if administered on the advice of a Physician) (In Iowa, only applies to the Sickness-Only Disability Income Rider) (In Maryland and Nevada, this exclusion does not apply)
- Participating in any sport or sporting activity for wage, compensation, profit, or racing any type of vehicle in an organized event; (In Idaho, this exclusion only applies if participating as a professional)
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip;
- War, or any act of war, whether declared or undeclared (In Oklahoma, when serving in the military or an auxiliary unit);
- Participating in any activity or event, including the operation of a vehicle, while intoxicated or under the influence according to the laws of the jurisdiction in which the accident occurred; (In Connecticut, involvement in a covered accident that occurs while the covered person is driving a motor vehicle while intoxicated or under the influence. "Intoxicated", according to Webster's New World Dictionary, 3rd College Edition, means "to affect the nervous system of, so as to cause a loss of control; make drunk; stupefy; inebriate as the result of alcoholic liquor. Being "under the influence" means according to the laws of the jurisdiction in which the accident occurs.), (In Idaho, this exclusion does not apply), (In Indiana, "under the influence" means under the influence of a controlled substance, unless administered by a physician or taken according to a physician's instructions), (In Maryland, this exclusion only applies to the Accidental Death and Dismemberment Rider and Disability Riders), (In Nevada, this exclusion does not apply), (In Oregon, Instigating or actively participating in a riot.) (In Pennsylvania, any loss sustained or contracted in the consequence of a covered person being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.) (In California, this exclusion does not apply if administered on the advice of a Physician)
- Participating in a riot, civil commotion, civil disobedience or unlawful assembly; (In Connecticut, "participating", according to Miriam-Webster Online Dictionary, 2009, means "to take part; to have a part or share in something." Also according to Miriam-Webster Online Dictionary 2009, "riot" means "public violence, tumult or disorder; a violent public disorder; specifically: a tumultuous disturbance of the public peace by three or more persons as-

sembled together and acting with a common intent."), (In Florida, participating in a riot or insurrection), (In Idaho, participating in a felony, riot or insurrection), (In Maryland, this exclusion does not apply), (In Utah, voluntarily participating in a felony, riot or insurrection)
- Committing, attempting to commit, or taking part in a felony or assault or engaging in an illegal occupation; (In Idaho, this exclusion does not apply), (In Maryland, this exclusion only applies to the Accidental Death and Dismemberment Rider and Disability Riders), (In Utah, voluntarily participating in illegal activities, limited to losses related directly to such participation)
- Intentionally self-inflicting bodily injury or attempting suicide while sane or insane; (In Missouri, while sane);
- Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.
- In Pennsylvania, Any loss for which benefits are provided under any Workers' Compensation, Occupational Disease Law, or by the United States Longshoreman's Harbor Workers' Compensation Act.

Termination of Coverage

Subject to the Portability Option, insurance coverage on the employee/member will end on the earliest of:

- The date of his or her death;
- The date he or she ceases to be eligible for coverage[1];
- The last date for which premium payment has been made to us, subject to the grace period;
- The date he or she terminates employment/membership[1];
- The date the group master policy terminates[1];
- The date he or she sends us a written notice to cancel coverage. (In California, the date we send you a 31-day written notice that we will cancel coverage.)

The insurance coverage on a dependent will cease on the earliest of:

- The date of the employee/member's death (In Illinois, 90 days after the date of the employee/member's death);
- The date the employee/member's coverage terminates;
- The last date for which premium payment has been made to us, subject to the grace period;
- The date the dependent no longer meets the definition of dependent;
- The date the certificate is modified so as to exclude dependent coverage[1];
- The date the employee/member sends us a written notice to cancel coverage on a dependent. (In California, the date we send you a 31-day written notice that we will cancel coverage on your Dependent.)

1 Not applicable in Florida and Montana

Extension of Benefits (Not available in Florida and Montana)

Whenever termination of coverage under this section occurs due to termination of employment/membership, such termination will be without prejudice to:

- Any hospital confinement which began while coverage was in force; or
- Any covered treatment or service for which benefits would be provided and which began while coverage was in force; provided, however that the covered person is and continues to be hospital confined or receiving treatment (In Maryland, Extension is available when coverage terminates for any reason except for termination due to failure to pay premium, fraud or material misrepresentation by the covered person, or if a succeeding health plan is provided at a cost that is less or equal to the cost of this coverage and does not result in an interruption of benefits)

Such Extension of Benefits will continue for up to the earlier of:

- 30 days (In Maryland, 12 months)(Not applicable in New Jersey); or
- The date on which the covered person is no longer hospitalized or receiving treatment.

Termination of the Group Master Policy (Not applicable in Florida and Montana)

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and coverage of all remaining insureds will end, subject to the Portability Option.

TRANSAMERICA LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("Insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

AccidentAdvance Application

☐ First Application ☐ Add Dependents – Certificate # _____ ☐ Increase Coverage – Certificate # _____

Group Name | Group Number | Location

Applicant (Last, First, M.I.) ☐ Male ☐ Female		Social Security No.	Date of birth	Date of marriage
Spouse [1] (Last, First, M.I.) ☐ Male ☐ Female		Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Annual salary	Occupation	Employee/Member ID

Home address | Work phone/ext.

City | State | Zip code | Home phone

Child(ren) name	Date of birth	Child(ren) name	Date of birth

Primary Beneficiary: (Last, First, M.I.) | Relationship:

Contingent Beneficiary: (Last, First, M.I.) | Relationship:

Applicant will be the beneficiary for any spouse and/or child(ren) coverage

[1] *Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the Insurer.*

Payment Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other_____

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family ☐ Two-Adult Family

		Premium per Payment Mode*
☐ Basic Accident Coverage (Applicant Only)		$
ADDITIONAL RIDERS: *(Only available if included in the plan selected by the policyholder)*		
☐ Applicant Accident Disability Rider	Monthly Benefit*:	$
☐ Applicant Sickness Disability Rider	Monthly Benefit*:	$
☐ Spouse Off-the Job Accident Disability Rider	Monthly Benefit*:	$
	Total Premium	$

*If increasing coverage, enter the **TOTAL** Monthly Benefit amount and Premium.

Eligibility Questions

1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation? If "No", you and your dependents are not eligible for coverage.	☐ Yes ☐ No
2. If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled? If "Yes", List name(s)_____, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No
3. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s)_____, who will be excluded from coverage.	☐ Yes ☐ No

The following questions should only be answered if the Sickness Disability Rider is included in the plan selected by the policyholder

4. In the ten years prior to the application date, have you been treated for, been diagnosed as having, or had any indication, sign or symptom of having any heart, brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, digestive, neurological, rheumatoid, or other major organ disorders, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form (except non-melanoma skin cancer)? If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement.	☐ Yes ☐ No
5. Do you have high blood pressure that is controlled by more than two medications? If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement.	☐ Yes ☐ No
6. In the past 12 months have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any condition in question 4? If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement.	☐ Yes ☐ No

Please provide details of all "Yes" answers to questions 2, 4, 5, and 6. Use additional paper if needed. For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.		
Question #	Name	Please list: Illness, Injury, Condition, Symptoms, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital

APPLICANT'S STATEMENTS AND AGREEMENTS:

For ID groups only:

Did you receive an Outline of Coverage describing the insurance for which you are applying? ☐ Yes ☐ No

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

For residents of all states not listed below:
I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

For residents of DC or LA:
I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of KY:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

For residents of NC or OR:
I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

For residents of NJ:
I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of OK:
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of TN:
It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of VT:
I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.

I understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the group must have met the Insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled (unless included by special endorsement), on the effective date (according to the Insurer's rules); and f) the first month's premium must have been received by the underwriting company at its administrative office.

I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .

Applicant's Signature _____ Spouse's Signature (if applicable) _____

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded on this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

Licensed Representative's Name _____ Licensed Representative's Signature _____ Agent # _____

YOUR FAMILY DESERVES A BETTER TOMORROW

CriticalAssistance® Advance
critical illness insurance

*Underwritten by **Transamerica Life Insurance Company**, Cedar Rapids, Iowa.*

A critical illness can impact your family at any time. It pays to be ready.

A recent study in Washington state found that compared to the general population, bankruptcy rates were nearly twice as high among cancer patients one year after diagnosis, and the median time to bankruptcy was two and a half years after diagnosis.[1] Critical Illness insurance can help you and your family prepare for the financial stress a critical illness can cause.

Understanding CriticalAssistance® Advance

CriticalAssistance Advance is designed to come to the rescue of those budget-conscious families by helping pay the costs associated with the initial occurrence of a heart attack, stroke, cancer or other serious illness as defined in the policy. You choose your benefit amount. Benefits are also available for your spouse and eligible children. Their benefit amount will be 50% of the benefit you elect.

Critical Illness Lump Sum Benefit

Pays you a lump sum benefit equal to the amount you choose multiplied by the applicable percentage shown in the Schedule of Benefits upon the first ever occurrence of a covered critical illness within each category. If the benefit payment is less than 100% of the selected benefit amount, the policy pays another lump sum benefit amount upon the diagnosis of a different type of critical illness within the same category up to the limit per category. There is a lifetime maximum of three times the benefit amount you choose.

Issue Ages

Employee and spouse from age 18 and up, eligible children from birth through age 25.

Additional Benefit Riders

Cancer Benefit Rider
Recurrent Critical Illness Benefit Rider
Wellness Benefit Rider

Payments can be used to cover related expenses, medical or otherwise, including:

Deductibles, co-pays, hospital bills and other medical expenses

Child care or house-sitting for the family pet

Credit card payments and other household bills

Travel to out-of-town hospital or treatment facility

Non-medical expenses like missed work and house-keeping

1 American Heart Association, Heart Disease and Stroke Statistics-2011 Update, http://circ.ahajournals.org/content/123/4/e18.full.pdf, accessed on Nov. 6, 2012.
2 U.S. Department of Health and Human Services, Organ Procurement and Transplantation Network Statistics. http://optn.transplant.hrsa.gov/, accessed on Nov. 6, 2012.
Use of statistic does not imply endorsement.

This is a brief summary of CriticalAssistance Advance, Critical Illness Insurance. Policy form series CPCI0400 and CCCI0400.

Forms and form numbers may vary and this coverage may not be available in all jurisdictions. Limitations and Exclusions apply. Refer to the policy, certificate and riders for complete details.

TRANSAMERICA®
Employee Benefits

CCA01C(Pape)-0612

CriticalAssistance® Advance
critical illness insurance policy

Summary of Benefits

Critical Illness Lump Sum Benefit (Policy not available in CA, CO, FL,GA, MN, NJ, NY, WA & PR)

CriticalAssistance® Advance pays you a lump sum benefit equal to the Elected Benefit multiplied by the applicable percentage shown in the Schedule of Benefits upon the first ever occurrence of a covered critical illness in each category. If the benefit payment is less than 100% of the selected benefit amount, we will pay a lump sum benefit amount upon the diagnosis of a different type of critical illness within the same category up to the limit per category or lifetime maximum. The maximum lifetime benefit is three times the selected lump sum benefit amount.

Additional Benefit Riders

Cancer Benefit Rider (Category 3)

This rider adds Invasive Cancer, Bone Marrow Transplant, Carcinoma in Situ, Prostate Cancer with TNM Classification of TI and Skin Cancer to the list of covered Critical Illnesses.

Recurrent Critical Illness Benefit Rider (Not Available in MA)

Pays a lump sum Recurrent Benefit equal to the Elected Benefit times the Recurrent Benefit percentage times the applicable percentage if a covered critical illness is not eligible for payment under the Critical Illness benefit. If an insured has a recurrence of the same illness, they will be eligible for the recurrence benefit only if it has been at least 12 months since their prior diagnosis and they have been treatment free for at least 12 months.

Wellness Benefit Rider (Health Screening Benefit Rider in NH)

Pays the selected amount per calendar year for each covered person when a charge is incurred for one of the following health screening tests: biopsy, blood test for triglycerides, bone marrow testing, breast ultrasound, CA 125 (blood test for ovarian cancer), CA 15-3 (blood test for breast cancer), CEA (blood test for colon cancer), chest x-ray, colonoscopy, fasting blood glucose test, flexible sigmoidoscopy, hemocult stool specimen, mammography, Pap test, PSA (prostate-specific antigen tests), serum cholesterol test to determine HDL/LDL level, serum protein electrophoresis (blood test for myeloma), stress test on a bicycle or treadmill, or thermography. Benefit is limited to one payment per calendar year per covered person (not subject to the Lifetime Maximum Benefit).

CriticalAssistance Advance Limitations and Exclusions

We do not cover losses caused by, or as a result of, the following:

- Conditions other than those due to a covered Critical Illness.
- The covered person participating or attempting to participate in an illegal activity.
- The covered person intentionally causing self-inflicted injury.
- The covered person committing or attempting to commit suicide, whether sane or insane.
- The covered person's involvement in any period of armed conflict.
- Surgeries performed outside the United States or its Territories.

Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

We may reduce or deny a claim or void coverage for loss incurred by a covered person during the first 2 years from the effective date of such coverage for any misstatements in the application which would have materially affected our acceptance of the risk or at any time for fraudulent misstatements in the application.

Termination of Coverage

Employee coverage will terminate on the earliest of:

- The date of the employee's death;
- The date on which the employee ceases to be eligible for coverage;
- The last date for which premium payment has been made to us;
- The last date on which employment terminates;
- The date the group master policy terminates; or
- The date the employee sends us a written notice to cancel coverage.

Dependent coverage will terminate on the earliest of:

- The date the employee's coverage terminates;
- The last date for which premium payment has been made to us;
- The date the dependent no longer meets the definition of dependent;
- The date the group master policy is modified so as to exclude dependent coverage; or
- The date the employee sends us a written notice to cancel dependent coverage.

We will have the right to terminate the coverage of any covered person who submits a fraudulent claim under the policy.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, coverage can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue coverage.

Waiting Period

There is no waiting period.

CriticalAssistance Advance Rider Limitations and Exclusions

Cancer Benefit Rider (Category 3)

Pays only for loss as a direct result of cancer or bone marrow transplant. We will not pay for any disease or incapacity that has been caused, complicated, worsened, or affected by, or as a result of cancer or its treatment.

Recurrent Critical Illness Benefit Rider

A recurrence of the same type of critical illness is not considered a Recurrent Critical Illness unless the diagnosis for the prior occurrence was at least 12 months from the most recent diagnosis and the person has been Treatment Free for at least 12 months. Treatment Free means the person is no longer receiving care from a physician, nor regular office visits, or being prescribed medication for a critical illness, other than routine checkups or maintenance medication for that critical illness.

Producer compensation information is available at www.tebcs.com

CriticalAssistance® Advance critical illness insurance

Underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa.

LIFE **HEALTH**

Category 1: Heart Attack, Stroke, Heart Transplant, Coronary Bypass Surgery, Angioplasty/Stent
Category 2: Major Organ Transplant, End-Stage Renal Failure, Paralysis, Burns, Coma, Loss of Sight/Speech/Hearing, Alzheimer's Disease
Optional Riders: Recurrent Critical Illness Benefit Rider (50%)
Cancer Benefit Rider
Wellness Benefit Rider ($150)

Weekly Premiums

		Age	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
Non-Tobacco User	Employee	18-29	$ 3.11	$ 3.75	$ 4.38	$ 5.01	$ 5.65	$ 6.28	$ 6.92	$ 7.55	$ 8.19
		30-39	3.39	4.16	4.93	5.71	6.48	7.25	8.03	8.80	9.57
		40-49	4.91	6.45	7.98	9.51	11.05	12.58	14.12	15.65	17.19
		50-59	7.66	10.56	13.47	16.38	19.29	22.20	25.10	28.01	30.92
		60-64	14.40	20.67	26.95	33.23	39.50	45.78	52.06	58.33	64.61
		65+	16.70	24.13	31.56	39.00	46.43	53.86	61.29	68.72	76.15
	1 Parent Family	18-29	$ 3.68	$ 4.33	$ 4.99	$ 5.65	$ 6.31	$ 6.96	$ 7.62	$ 8.28	$ 8.94
		30-39	3.95	4.75	5.55	6.34	7.14	7.93	8.73	9.53	10.32
		40-49	5.48	7.03	8.59	10.15	11.71	13.26	14.82	16.38	17.94
		50-59	8.22	11.15	14.08	17.01	19.95	22.88	25.81	28.74	31.67
		60-64	14.96	21.26	27.56	33.86	40.16	46.46	52.76	59.06	65.36
		65+	17.27	24.72	32.18	39.63	47.08	54.54	61.99	69.45	76.90
	2 Parent Family	18-29	$ 5.34	$ 6.13	$ 6.93	$ 7.73	$ 8.52	$ 9.32	$ 10.11	$ 10.91	$ 11.71
		30-39	5.91	7.00	8.08	9.17	10.25	11.34	12.42	13.51	14.59
		40-49	8.22	10.46	12.70	14.94	17.18	19.41	21.65	23.89	26.13
		50-59	11.98	16.10	20.22	24.34	28.46	32.58	36.70	40.82	44.94
		60-64	22.07	31.23	40.39	49.55	58.71	67.88	77.04	86.20	95.36
		65+	24.08	34.24	44.41	54.57	64.74	74.90	85.07	95.23	105.40

		Age	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
Tobacco User	Employee	18-29	$ 4.31	$ 5.55	$ 6.78	$ 8.01	$ 9.25	$ 10.48	$ 11.72	$ 12.95	$ 14.19
		30-39	4.80	6.27	7.75	9.23	10.70	12.18	13.66	15.13	16.61
		40-49	8.00	11.08	14.16	17.25	20.33	23.41	26.49	29.57	32.65
		50-59	14.53	20.88	27.23	33.57	39.92	46.26	52.61	58.96	65.30
		60-64	26.19	38.36	50.53	62.71	74.88	87.05	99.23	111.40	123.57
		65+	28.86	42.38	55.89	69.40	82.91	96.42	109.93	123.45	136.96
	1 Parent Family	18-29	$ 4.88	$ 6.13	$ 7.39	$ 8.65	$ 9.91	$ 11.16	$ 12.42	$ 13.68	$ 14.94
		30-39	5.36	6.86	8.36	9.86	11.36	12.86	14.36	15.86	17.36
		40-49	8.57	11.67	14.78	17.88	20.98	24.09	27.19	30.30	33.40
		50-59	15.10	21.47	27.84	34.21	40.58	46.95	53.31	59.68	66.05
		60-64	26.75	38.95	51.15	63.34	75.54	87.73	99.93	112.13	124.32
		65+	29.43	42.96	56.50	70.03	83.57	97.10	110.64	124.17	137.71
	2 Parent Family	18-29	$ 6.84	$ 8.38	$ 9.93	$ 11.48	$ 13.02	$ 14.57	$ 16.11	$ 17.66	$ 19.21
		30-39	7.37	9.18	10.99	12.80	14.61	16.43	18.24	20.05	21.86
		40-49	12.61	17.04	21.47	25.90	30.33	34.76	39.19	43.62	48.05
		50-59	22.55	31.96	41.36	50.76	60.17	69.57	78.98	88.38	97.78
		60-64	39.86	57.92	75.98	94.03	112.09	130.15	148.21	166.26	184.32
		65+	43.71	63.70	83.68	103.67	123.65	143.64	163.62	183.61	203.59

This custom plan is incomplete without a state-specific proposal or brochure, which describes the benefits, exclusions, and limitations of policy form CPCI0400 or state variation thereof.

Issue State: Iowa
Ver. 14 - 11/9/2012

TRANSAMERICA LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

CriticalAssistance® Advance Employee Application

☐ First Application ☐ Add Dependents – Certificate # _____ ☐ Increase Coverage – Certificate # _____

Group Name | Group Number | Location

Applicant (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Home phone
Email Address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No		Have you used tobacco products in the last year? ☐ No ☐ Yes	
Date of hire	Avg hours worked per week	Occupation	Applicant ID	Work phone/ext.
Home address	City	State	Zip code	

Full name of dependents for which coverage is being applied for.	Relationship to Applicant	Date of Birth	Social Security No.	Used tobacco products in the last year?
				☐ No ☐ Yes
				Does not apply to children

Payment Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family

		Benefit Amount*	Premium Per Pay Mode*
Critical Illness Insurance	Plan (if applicable)	$	$

*If increasing coverage, enter the **TOTAL** Benefit Amount and Premium.

Eligibility Questions

1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation? ☐ Yes ☐ No
   If "No", you and your dependents are not eligible for coverage.
2. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? (**DO NOT** answer if you are a resident of KY) ☐ Yes ☐ No
   If "Yes", List name(s)_____, who will be excluded from coverage.

Evidence of Insurability Questions

	Applicant /	Spouse /
3. Indicate height and weight for :		
4. Has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease? If "Yes", List name(s)_____, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No	
5. In the ten years prior to the application date, has any proposed insured been treated for, been diagnosed as having, or had any indication, sign, or symptom of having any heart (including heart attack), lung, brain, circulatory, respiratory, blood, vascular (including stroke), neurological, kidney, liver, pancreas, rheumatoid, or reproductive disorders, diabetes, optic neuritis, fibromyalgia, or chronic fatigue syndrome, had any medical or surgical procedures recommended (including major organ transplant) or advised by a physician but not done at this time, or, in the two years prior to the application date, been treated or counseled for alcohol or drug abuse? If "Yes", List name(s)_____, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No	
6 Does any proposed insured have high blood pressure that is controlled by more than two medications? If "Yes", List name(s)_____, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No	

Only answer if the coverage you are applying for includes the Cancer Benefit Rider

7. In the ten years prior to the application date, has any proposed insured been diagnosed as having or been treated for any form of internal cancer, or malignancy (excluding basal cell skin cancer) which includes leukemia, Hodgkin's Disease, carcinoma, sarcoma, lymphoma, or malignant tumors? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No

8. In the past 12 months, has any proposed insured been recommended for any medical treatment that has not yet been completed, undergone a biopsy or other diagnostic test, or is now scheduled for such to determine whether any form of cancer or malignancy exists, other than a regular Pap Smear, Mammogram, Colonoscopy, or PSA test? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No

Please provide details of all "Yes" answers to questions 4, 5, 6, 7, and 8. Use additional paper if needed.
For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Question #	Name	Please list: Illness, Injury, Condition, Symptoms, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital

APPLICANT'S STATEMENTS AND AGREEMENTS:

For residents of CA, GA, MA, and MN only: Are all proposed insureds covered under major medical, hospital, or medical expense insurance, or an HMO contract? ☐ Yes ☐ No If "No", list names _____, who will be excluded from coverage. Coverage will not be issued to anyone who does not have comprehensive medical coverage. If applicant answers "No", no coverage will be issued.

For ID, MA, MT, NH and NJ applicants only: Did you receive an Outline of Coverage describing the insurance you are applying for? ☐ Yes ☐ No

I have read or had read to me the completed application. **I represent** that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

For All states not listed below: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

For DC, LA, MD or RI: I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For KY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

For MA or NC: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

For OK: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For VT: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.

I understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work on the effective date (according to the insurer's rules); and f) the first month's premium must have been received by the underwriting company at its administrative office. **I understand** that completion of this application in no way implies that I will be accepted for insurance coverage.

For MA: Caution: If your answers on this application are incorrect or untrue, we have the right to deny benefits or rescind your coverage.
For NH: I understand that a person to be covered for specified disease insurance cannot also be covered by any Title XIX Program (Medicaid).
THE POLICY/CERTIFICATE PROVIDES LIMITED BENEFITS. IF ACCEPTED FOR COVERAGE, READ YOUR CERTIFICATE CARFULLY.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____.

Applicant's Signature _____ Spouse's Signature (if applicable) _____

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded in this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

Licensed Representative's Name | Licensed Representative's Signature | Agent #